PLEASE PRINT **Date ________________**

Patient Name ____
Last First MI

Date of Birth ______________________ Age __________ Height ____________ Weight ______________

Antihistmine or Drug Allergies ____

What prescription/non prescription medicine / supplements do you take? (Additional space on back of form)

____

PAST MEDICAL HISTORY Have you ever had the following? (Check yes or no. Leave blank if uncertain)

Condition	Yes	No
AIDS or HIV +	❑ Yes	❑ No
Anemia	❑ Yes	❑ No
Arthritis	❑ Yes	❑ No
Asthma	❑ Yes	❑ No
Back Trouble	❑ Yes	❑ No
Bladder Infections	❑ Yes	❑ No
Bleeding Tendency	❑ Yes	❑ No
Bronchitis	❑ Yes	❑ No
Cancer	❑ Yes	❑ No
Chickenpox	❑ Yes	❑ No
Diabetes	❑ Yes	❑ No
Diphtheria	❑ Yes	❑ No
Glaucoma	❑ Yes	❑ No
Heart Disease	❑ Yes	❑ No
Hemorrhoids	❑ Yes	❑ No
Hepatitis	❑ Yes	❑ No
Hernia	❑ Yes	❑ No
High or Low BP	❑ Yes	❑ No
Hives or Eczema	❑ Yes	❑ No
Infectious Mono	❑ Yes	❑ No
Kidney Disease	❑ Yes	❑ No
Measles	❑ Yes	❑ No
Migraines	❑ Yes	❑ No
Mitral Valve	❑ Yes	❑ No
Pneumonia	❑ Yes	❑ No
Mumps	❑ Yes	❑ No
Polio	❑ Yes	❑ No
Rheumatic Fever	❑ Yes	❑ No
Scarlet Fever	❑ Yes	❑ No
Smallpox	❑ Yes	❑ No
Stroke	❑ Yes	❑ No
Transfusions	❑ Yes	❑ No
Tuberculosis	❑ Yes	❑ No
Ulcer	❑ Yes	❑ No
Venereal Disease	❑ Yes	❑ No
Whooping Cough	❑ Yes	❑ No

Any other disease – Please list

____

____

THE LAST TIME YOU HAD (list year)

Cholesterol Test ______________ Rectal Exam ______________
Eye Exam ______________ Rubella Vaccine ______________
Flu Vaccine ______________ Sigmoidoscopy ______________
Hepatitis Vaccine ______________ Stool Blood Test ______________
Pneumonia Shot ______________ TB Test ______________
PSA Test ______________ Tetanus Shot ______________

SOCIAL HISTORY

Alcohol ❑ Yes ❑ No drinks/week ______________
Caffeine ❑ Yes ❑ No cups/day______________
Illegal Drugs ❑ Yes ❑ No type ______________
Tobacco ❑ Yes ❑ No pack/day __________ years __________

Relative	Age	Deceased	Health Problems
Father			
Mother			
Siblings			
Grandparents			

Year	Illness / Operation

FOR FEMALES ONLY

Age onset menstrual period ____________ Date last menstrual period ______________
Duration of periods ____________ Date of last PAP Test ______________
Had painful menstruation? ❑ Yes ❑ No Had irregular menstruation? ❑ Yes ❑ No
Use birth control? ❑ Yes ❑ No Type ______________
YEAR OF LAST Breast Exam ______________ Was it normal? ❑ Yes ❑ No
Number of pregnancies ____________ Number of abortions ______________
Number of live births ____________ Number of miscarriages ______________

FOR MALES ONLY

Any Swelling of testicles? ❑ Yes ❑ No Any problems obtaining or maintaining an erection? ❑ Yes ❑ No

PATIENT IDENTIFICATION LABEL

MAX SPORTS MEDICINE

PATIENT HEALTH QUESTIONNAIRE

3006664 (717/2009)

Patient Name______________________________ Date ______________

MEDICATIONS & SUPPLEMENTS	DOSE & FREQUENCY